REQUEST for STAKEHOLDER COMMENT
Design and Development of an Insurance Exchange in Connecticut

The following information is organized by general topic area, with a list of questions we would like you/your organization to answer as you feel appropriate. These questions are followed by background briefings to provide a general understanding of the topics. To encourage productive discussion during each meeting, we are providing you this information in advance of your meeting. While these topic areas are the specific issues for which public comment is requested, please feel free to offer any other comments on policies related to the Exchange and the insurance market as well.

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QUESTIONS

Please provide us with your thoughts and insights on the questions listed below as you feel appropriate.

A. Establish a Responsive and Efficient Structure

1. Should Connecticut consider joining a multi-state Exchange? Under a regional Exchange, would Connecticut benefit most from a separate or merged risk pool?

Anthem opposes the development of multi-state or regional exchanges due to difficulties related to governing laws, enforcing consumer protections, and regulator jurisdiction. Achieving affordable, quality health care requires adequate rules to protect consumers and maintain confidence in the private health insurance market's ability to drive additional value and affordability—rules which multi-state exchanges put at risk. Anthem embraces a competitive insurance environment; however, all competitors offering coverage to a given individual must be subject to the same rules and regulations.

If the formation of multi-state exchanges is considered to lower administrative costs among neighboring states, Anthem urges the state to ensure that state insurance markets must remain separate and distinct (e.g., products, risk pools, etc.).

2. Should Connecticut administer the Exchanges for the individual and small group markets separately or jointly? If jointly, should Connecticut maintain separate risk pools for the two Exchanges, or merge the risk pools.

Anthem believes it is important for states to maintain separate and distinct markets for individuals and small groups, regardless of whether or not a state decides to consolidate exchanges administratively to gain efficiencies. These separate markets would include separate risk pools, as combining risk pools for the individual and small group markets is likely to lead to higher rates for small groups due to adverse selection. Maintaining separate markets will also allow health insurers to tailor benefit designs to meet the needs of each market, and thus better serve individuals and small employers.

Additionally, Anthem feels strongly that states should permit plans to decide whether or not to sell coverage to either or both of the markets – inside or outside of the exchange. Carrier choice in this regard will increase plan participation, encouraging competition and resulting in higher quality plans. Further, health plans should be able to continue to offer different products to the different markets to best serve the needs of consumers.

3. Should Connecticut open the Exchange to businesses with 2-100 employees in 2014, or should it allow businesses with 2-50 employees in 2014 and increase participation to businesses with 51-100 employees in 2016?

Anthem believes that the definition of small employer should be limited to 50 until 2016. This will allow the exchange time to optimize systems for individuals and smaller groups before extending eligibility beyond that which is required.

Further, larger groups have different needs than smaller ones, and tend to be sophisticated purchasers of coverage, so it is unlikely that an exchange designed for smaller employers will be attractive to larger employers.

State rating approaches may also differ for employers with 1 to 50 employees and those with 51 to 100 employees, with rating for smaller groups often being more restricted. Permitting larger small groups to purchase coverage on the exchange prior to 2016 will result in earlier recognition of significant market disruption for this segment, leading to adverse selection as healthier groups have greater incentive to self-insure when faced with more restrictive rating.

Further, as groups get larger, they are more likely to have the means to self-insure. This means that there is an even greater increased risk for adverse selection into the exchange as group size increases because healthier groups are more likely to self-insure and less healthy groups are more likely to seek coverage in the exchange.

4. Should Connecticut seek to expand access to businesses with more than 100 employees in 2017, with HHS approval?

No. Again, Anthem opposes allowing large employers (those with more than 100 employees) to purchase coverage through the exchange. As noted above, larger groups have different needs than smaller ones, and tend be sophisticated purchasers of coverage, so it is unlikely that an exchange designed for small employers will be attractive to larger employers. Larger groups are also more likely to self-insure which will increase the risk for adverse selection into the exchange increasing costs for all fully insured groups.

B. Address Adverse Selection and the External Market

1. Should Connecticut allow a dual market, a hybrid market, or should it require that all individual insurance be sold through the Exchange? Under a dual market scenario, what additional rules should Connecticut establish to prevent insurers from discouraging participation in the Exchange? What hybrid models might Connecticut consider, and what characteristics do they offer that would benefit Connecticut?

Anthem supports a dual market in Connecticut in which there is the continued operation of the state's existing individual and small group markets outside of the exchange. Anthem believes that Congress made it clear in its drafting of the ACA that its intent was for the outside market to continue despite formation of state health insurance exchanges.

- Section 1312(d)(1) of the ACA, which is titled "Continued Operation of Market Outside Exchanges," speaks to this intent: "Nothing in this title shall be construed to prohibit – A) a health insurance issuer from offering outside of an exchange a health plan to a qualified individual or qualified employer; and B) a qualified individual enrolling in, or a qualified employer from selecting for its employees, a health plan offered outside of an exchange."
- Section 1312(d)(3), titled "Voluntary Nature of an Exchange," goes on to further support the market outside the exchange by declaring that "nothing in this title shall be construed to restrict the choice of a qualified individual to enroll or not enroll in a qualified health plan or to participate in an exchange." Further, "nothing in this title shall be construed to compel an individual to enroll in a qualified health plan or to participate in an exchange." And Section 1312(d)(4) declares that no penalty or fee shall be applied to any individual by an exchange or a QHP offered via an exchange who cancels enrollment in a QHP to enroll in coverage outside the exchange.

Additionally, Anthem believes that other portions of the law also support the continued operation of a health insurance market outside of an exchange, and simultaneously represent necessary efforts to protect against adverse selection within the exchanges. Section 1201, which amends section 2707(a) of the PHSA, states that health plans must meet the same essential benefit requirements that apply to coverage offered through an exchange for any coverage offered in the non-group or small group market. Section 1301(a)(1)(B) states that premiums for a particular qualified health plan must be the same regardless of whether the plan is purchased through an exchange, directly from a carrier or through a broker.

Finally, while outside of the exchange plans must still meet the requirements of the ACA, they should otherwise be able to offer any combination of the different plan levels available within the exchange (bronze, silver, gold, and platinum) that they choose, or not offer coverage outside of the exchange at all. While there are protections included in the federal law to help mitigate adverse selection in the exchange, it is important for market rules to be the same inside and outside of the exchange to further prevent adverse selection.

2. Are there any additional mechanisms to mitigate adverse selection that Connecticut should consider implementing as part of the Exchange?

Again, while there are protections included in the federal law to help mitigate adverse selection in the exchange, it is important for market rules to be the same inside and outside of the exchange to further prevent adverse selection. Any requirements should ensure a level playing field between health plans participating in the exchange, and as such, there should be no exemptions from certification standards for any particular type of plan – whether traditional health insurers, Medicaid plans, provider-sponsored plans, or Consumer Operated and Oriented Plans (CO-OPs).

Additionally, the following mechanisms will further help to mitigate adverse selection:

- Standardized Open Enrollment periods should be utilized to avoid adverse selection and promote efficient enrollment periods.
  - *Individual Market: T*o help mitigate adverse selection resulting from guarantee issue requirements, Anthem believes that a single, annual, 30-day open enrollment period should be specified for the individual market. The same open enrollment period should be used off the exchange (or should at least be an

option for carriers) to avoid adverse selection off the exchange. Anthem also supports the formation of a list of "special enrollment events" that would allow an individual to purchase coverage outside of the open enrollment periods.

- *Small Group Market:* Carriers should have the flexibility to provide continuous guaranteed issue in the small group market. However, once employers enroll in an exchange, their employees must select plans within 30 days (consistent with how employer plans generally address initial open enrollment today) and adhere to special enrollment periods outside of this period. To help avoid adverse selection, sole proprietors should follow a process consistent with the individual market, and be subject to the same single, annual 30-day open enrollment period as the individual market.
- Additionally, switching of carriers or plans and buying-up or down during the OE period should be limited to minimize the risk of adverse selection.

- Employer plan choice will minimize market disruption and promote a healthy small group market inside and outside the exchange.
  - Regarding employer/employee plan choice, Anthem believes that, under the ACA, employers are permitted (and should) select specific health plans and carriers for their employees within the small group (SHOP) exchange. Taking this approach will minimize disruption in the small group market and ease the transition to the exchange for small employers who currently offer coverage to their employees and who choose to renew their plans through the SHOP exchange. Further, allowing employees of qualified employers participating in the exchange to select from all products from all health plans at the selected metallic level would have unintended consequences—e.g., greater administrative burdens and costs on small groups related to billing, premium payments and managing eligibility, and increased adverse selection.

3. How should the temporary reinsurance program be approached in Connecticut? What issues should Connecticut be aware of in establishing these mechanisms?

Connecticut should leverage its existing infrastructure and expertise, as garnered through its effective administration of the Connecticut High Risk Association (HRA) and the Connecticut Small Employer Health Reinsurance Plan (CSEHRP). This will promote administrative ease and cost-effectiveness.

C. Simplify Health Insurance Purchase

1. What issues should Connecticut consider in establishing a Navigator program?

Anthem believes that navigators should be impartial (with respect to health plans, providers, etc.) and that their roles should be limited to the requirements set forth under the ACA.

2. What should Connecticut consider regarding the role of insurance brokers and agents?

Anthem believes that brokers should continue to play a key role in the sale of health insurance inside and outside of an exchange. This is especially true for the small group market, in which brokers often help small businesses with more than the simple election of a health insurance plan.

In order to make the exchange a viable marketplace, Anthem believes that brokers must not have any incentives to channel business solely inside or outside of the exchange. As noted above, Anthem believes that brokers should complement the role of navigators, who must be impartial (with respect to health plans, providers, etc.) and whose role should be limited to the

requirements set forth under the ACA. To that end, Anthem supports health plans being allowed to set broker commissions for sales outside of an exchange and also for coverage sold through an exchange.

D. Increase Access to and Portability of High Quality Health Insurance

1. Should Connecticut allow any plan that meets Qualified Health Plan standards to be available in the Exchange, or should Connecticut establish additional requirements? If additional requirements, what would you recommend? What would be impact of those requirements?

   In order to maximize choice, competition and health plan participation, Anthem opposes the establishment of additional requirements on Qualified Health Plans within exchanges beyond those required by the ACA.

   Because exchanges are intended to be new competitive markets for health insurance that will enable individuals and small employers to meaningfully choose among competing health plans on an annual basis, exchanges will be most effective in this role if they are facilitators of coverage options approved for sale by insurance regulators that meet QHP standards. Exchanges should not be a new and potentially duplicative or conflicting regulatory entity that could limit the ability of individuals and small employers to enroll in a health plan that meets their specific needs and disrupt the market.

2. Should Connecticut consider establishing the Basic Health Program? What would the Basic Health Program offer as a tool to facilitate continuity of coverage and care?

   Undecided.

3. How would the Basic Health Program impact other related programs in Connecticut?

   Undecided.

4. How can Connecticut structure its Exchanges to maximize continuity of coverage and seamless transition between public and private coverage? (E.g. as a person moves from Medicaid, subsidized and non-subsidized markets)?

   Anthem recognizes that there are complicated issues surrounding the interactions between Medicaid and the Exchange. While we are engaging in a great deal of internal thinking on these issues, we have not yet come to a finalized position. While seamlessness will be important, it is also critical to note that significant differences exist with respect to the benefit requirements, cost-sharing levels and networks.

Ensure Greater Accountability and Transparency

1. What information should Connecticut include for outreach to most effectively engage consumers? How should the information be presented?

   Anthem believes that information should be provided to consumers regarding cost and quality in a way that helps them make informed decisions. For example, the Exchange should make provider "report cards" available to consumers.

2. How should Connecticut ensure ongoing feedback and input about accountability, operational issues, and suggested improvements?

Exchange governance must be structured to ensure ongoing feedback about accountability, operational issues and suggested improvements. Regardless of the governance structure, Connecticut's exchange should leverage existing state capabilities and efficiencies and include formal, ongoing consultation with key stakeholders relevant to carrying out the activities the exchange is required to conduct under federal law so that the exchange runs efficiently and is able to fulfill its key duties. Such stakeholders should include, at minimum, the following:

- Consumers;
- Health plan enrollment experts;
- Department of Insurance representative(s);
- State Medicaid office representative(s);
- Consumer advocates who can assist in involving hard-to-reach populations;
- Providers;
- Small business owners and self-employed persons; and
- Health insurers and HMOs marketing within the state.

Further, Anthem believes that it is imperative that the exchange have reporting and fiduciary accountability to appropriate state authorities, such as the department of insurance, state legislature or Governor's Office. There must also be requirements that the governing body's work be done in a transparent way and that there be a formal redress process in case issues should arise, and the governing entity of the exchange should not be an elected position as exchanges should be free from overt political influence concerning the plan choices available to individuals or small employers.

Finally, the exchange should develop governing documents that explicitly incorporate ethics standards, accountability to members, freedom from undue influence, transparency requirements and fiduciary standards.

3. What information, beyond that required under the ACA and implementing regulations, should Connecticut require of plans? How much of this information should be shared with consumers accessing the Exchange?

Anthem opposes the imposition of additional requirements on qualified health plans within exchanges beyond those required by the ACA. Existing regulations are sufficient and additional requirements would minimize competition, choice and health plan participation in exchanges.

Should Connecticut insist on adopting additional certification standards, they should use existing nationally accepted accreditation programs, such as NCQA or URAC, as a proxy for certification. Further, any requirements should ensure a level playing field between health plans participating in the exchange. As such, there should be no exemptions from certification standards for any particular type of plan – whether traditional health insurers, Medicaid plans, provider-sponsored plans, or Consumer Operated and Oriented Plans (CO-OPs).

E. Self-Sustaining Financing

1. How should the Exchange's operations be financed beginning in 2015?

Anthem believes that funding for health insurance exchanges should be broad-based so that the exchange is financially sustainable. Health insurance exchanges should evaluate all available funding sources to support continuing administrative and operational expenses, including grants, fees, assessments and taxes — including tobacco taxes. If administrative and operational expenses are to be supported by insurance, or levied on insurance, including if limited to exchange products, then pricing should be transparent and allow for a pass through of this additional cost of doing business. Such assessments should not exceed two dollars per member per month (PMPM). Furthermore, all exchange assessments should be separated from general

funds and used solely for the operation of the exchange. In addition, all assessments should be excluded from the calculation for Minimum Loss Ratio purposes, consistent with other state insurance assessments. Lastly, the governing body of the exchange should be accountable to the appropriate state entity with respect to the amount and use of the assessment.

2. How might the state's financing strategies encourage or discourage participation in the Exchange; affect the reputation of the Exchange; and affect accountability, transparency, and cost-effectiveness?

To ensure cost-effectiveness, transparency and accountability, all exchange assessments should be separated from general funds and used solely for the operation of the exchange. As noted above, if administrative and operational expenses are to be supported by insurance, or levied on insurance, including if limited to exchange products, then pricing should be transparent and allow for a pass through of this additional cost of doing business. Limiting assessments to Exchange-certified Qualified Health Plans would have the benefit of increasing the incentives for the Exchange to be administratively efficient to be competitive in the marketplace. In addition, all assessments should be excluded from the calculation for Minimum Loss Ratio purposes, consistent with other state insurance assessments. Lastly, the governing body of the exchange should be accountable to the appropriate state entity with respect to the amount and use of the assessment

3. What issues should be considered regarding state requirements for additional benefits above the minimum essential benefits? What funding sources should be considered for the cost of additional benefits?

Additional benefits beyond those set forth by the ACA should not be required. Once implemented, the ACA consumer-oriented insurance market reforms require plans to cover preventive services, define an essential health benefits package and set the percentage of premiums earned that must be spent on clinical services and quality improvements. These requirements will create a strong floor for all health plan offerings, and additional benefit requirements will have the unintended consequences of stifling product innovation and limiting consumer choice. Mandating additional benefits could also hurt the affordability of Exchange products if the additional costs are ultimately passed on to consumers.

F. Under the ACA, an Exchange is responsible for performing a specified list of functions. However, many decisions are left to the states.

1. Beyond the Exchange's minimum requirements, are there additional functions that should be considered for Connecticut's Exchange? Why?

Anthem believes that exchanges, in concert with applicable state agencies, should be responsible for determining eligibility for premium subsidies, any public programs and for providing this information to health plans in a timely manner to allow for proper plan administration. States and exchanges are likely in the best position to readily have access to the sensitive information required to make these determinations and to have information technology systems that can be used for the basis for such systems within an exchange.

Functions that should not be managed by Exchanges include the following:

- Price regulation should remain a function of the Insurance Regulator.
- Billing and premium collection should be managed by health plans, not exchanges.
- Health plans should retain authority to set broker commissions for sales outside of an exchange and also for coverage sold through an exchange.

2. Are there advantages to limiting the number of plans offered in the Exchange, or is the Exchange a stronger marketplace if it permits "any willing provider" to sell coverage?

In order to maximize choice, competition and health plan participation and minimize regulatory duplication and confusion and market disruption, Anthem believes that all carriers with plans that meet the qualified health plan (QHP) standards required by the ACA and later promulgated by the Secretary should be permitted to offer such plans in an exchange. As such, Anthem supports a "facilitator" exchange model.

Anthem believes that by engaging in selective contracting exchanges will limit the number of plans available to individuals and small employers and undermine the incentive for plans to develop exchange offerings. This may leave many individuals and small employers unable to find a plan that is right for them on the exchange, which could drive them off the exchange, or to not enroll in coverage at all. As such, Anthem opposes exchanges engaging in selective contracting or bidding. Anthem firmly believes that by acting as a facilitator that is subject to appropriate federal and state requirements, exchanges can best ensure a sufficient number of high value health plans are available to fit the unique needs of different individuals and small employers.

3. Should Connecticut consider setting any conditions for employer participation in the small group exchange (e.g. minimum percent of employees participating, minimum employer contribution, limits in the range of product benefit values that may be selected by employees, etc)?

Yes. Connecticut should consider requiring employers purchasing coverage for their employees in the Exchange to have a minimum percentage of their employees participating. Anthem also supports employers purchasing coverage in the Exchange being required to make a minimum contribution towards their employees' health plans.

Regarding employer/employee plan choice, Anthem believes that, under the ACA, employers are permitted (and should) select specific health plans and carriers for their employees within the small group (SHOP) exchange. Taking this approach will minimize disruption in the small group market and ease the transition to the exchange for small employers who currently offer coverage to their employees and who choose to renew their plans through the SHOP exchange. Further, allowing employees of qualified employers participating in the exchange to select from all products from all health plans at the selected metallic level would have unintended consequences—e.g., greater administrative burdens and costs on small groups related to billing, premium payments and managing eligibility.

4. What are some of the initiatives that could maximize flexibility and offer a value for small business employers to utilize the Exchange?

<u>Employer Choice</u>

To ease the transition to the exchange for small employers who currently offer coverage to their employees and who choose to renew their plans through a SHOP exchange, Anthem believes that employers should be to select specific health plans and carriers for their employees within the small group (SHOP) exchange, which the ACA supports:

- The very definition of a "qualified employer" in Section 1312(f)(2) of the ACA, is a small employer that elects to make all full time employees "eligible for 1 or more qualified health plans" offered through the exchange. We note that some have interpreted Section 1312(a) as allowing employees of qualified employers to choose any plan at the

specified level and thereby prohibiting employers from selecting one or more plans for their employees. However, this provision is clearly permissive in that an employer is not required to specify a level of coverage – they "may" specify a level of coverage – and only if they do can employees choose among plans at that level of coverage. Moreover, the definition of a qualified employer makes clear an employer may select a plan (or plans) for its employees.

- Further, allowing employees of qualified employers participating in the exchange to select from all products from all health plans at the selected metallic level would have unintended consequences. This would create significant new administrative costs and burdens on small groups related to billing, premium payments, managing eligibility, and answering benefit questions for employees.
- Employee choice within the exchange would also create adverse selection (for example, as less health employees select health plans from carriers with broader networks) and health plans will have to price accordingly for this risk. Because health plan products must be priced the same inside and outside of the exchange, this would increase premiums for all those seeking coverage. This phenomenon recently played out in Massachusetts where the Massachusetts Connector "Contributory Plan" pilot program for small businesses (which allowed for employee plan choice) was halted in February due to adverse selection issues. The new pilot, called "Business Express," adopts the traditional model where the employer picks the carrier, and employees choose the product.
- Additionally, substantial administrative problems would be created for employers with employees in multiple states if employees were allowed to obtain coverage from the exchange in the state in which they reside rather than the state where the employer is headquartered. Anthem believes that qualified employers should contract with the exchange in the state in which the employer is headquartered with respect to the employer choice option. This will ease administration and ensure that employers do not gravitate to the state exchange with the most lenient regulatory structure to seek coverage.

<u>Ensure Ease of Access to Small Employer Tax Credit</u>

- Connecticut should consider strategies for helping small employers determine their eligibility for the small employer tax credit, and also any processes that could make their application for and receipt of the credit as streamlined and as administratively simple as possible.

5. What should be the role of the Exchange in premium collection and billing?

Anthem believes that health plans, not exchanges, should continue to be responsible for billing policyholders and collecting premiums in the individual market. At a minimum, an individual enrolled in a QHP should have the option to pay his/her applicable premium directly to the issuing health plan as is required by the ACA. This responsibility ensures that health plans maintain an important connection to members while also ensuring that health plans are able to effectively comply with such state requirements as those regarding delinquent payments, non-payment of premiums, grace periods, related notifications and prompt payment to providers, etc.

6. What are all the different data collection and reporting mechanisms that are necessary to operate a transparent and accountable Exchange?

Anthem is still considering these issues. However, regardless of the mechanisms, Anthem believes that nationally recognized quality rating systems and measures, such as HEDIS or those developed by NQF, should be used to rate health plans participating in the exchange. It is imperative to use nationally recognized, industry vetted standards to ensure that reports on

quality ratings are objective, valid and comparable. Additionally, Anthem supports adoption of standardized data sharing formats for the collection of the minimum data necessary to operate the exchange and any risk adjustment programs to minimize the administrative burden of sharing information. The government should utilize existing industry standards wherever possible.

BACKGROUND by TOPIC AREA

The general information on each topic area below is intended for brief reference only.

A. Establish a Responsive and Efficient Structure

The ACA requires that all states establish an American Health Benefits Exchange for the individual market and a Small Business Health Options Program (SHOP Exchange) for the small group market. States may operate these independently or may combine them into a single Exchange. States may also form regional or multi-state Exchanges.

For the purpose of inclusion in the SHOP Exchange, the ACA defines small employers as an employer with 2-100 employees. However, until 2016, states may limit this definition to 2-50 employees; and after 2017 states may further expand participation in the SHOP Exchange.

B. Address Adverse Selection and the External Market

The ACA allows states to establish a "dual market" in which individual insurance may be purchased in and out of the Exchange, or to require that all health insurance plans sold on the individual market must be sold through the Exchange. States may also design "hybrid" solutions such as permitting supplemental coverage to be sold in external markets but requiring that all individual major medical coverage be sold in the Exchange.

The ACA establishes certain rules to protect against selection issues in a dual market, but does not deny states the ability to include additional requirements for insurance sold in the Exchange and an external market. State options include but are not limited to requiring that all insurers in the Exchange offer all four tiers of coverage, standardizing benefits packages, and restricting the sale of "catastrophic" insurance plans. However at a minimum, the following rules apply:

- Plans inside and outside of an Exchange must be in the same risk pool, have the same premium rate (for those sold by the same company), and meet the same minimum benefits standards.
- Insurers inside and outside the Exchange may not deny coverage on the basis of pre- existing conditions, medical status, or claims history.
- Premium variation based on age, geographic location, and smoking status must apply to plans sold both inside and outside the Exchange.
- Plans sold in the Exchange must have an open enrollment period and special enrollment periods to encourage participants to purchase coverage before they become sick.

The ACA requires that states establish a reinsurance program for the individual market inside and outside of the Exchange, for the first three years of Exchange operation. The NAIC will develop model legislation to carry out this provision. States must consider issues such as how to coordinate their high risk pools with this program.

C. Simplify Health Insurance Purchase

The ACA requires an Exchange to establish a "Navigator" program to conduct public education, advise individuals and small groups that enroll in the Exchange, help them enroll in health plan and access benefits, and provide referrals as needed to the health care ombudsman. The Navigator program must be established by awarding grants to a variety of groups, and must be financed through operational funds of the Exchange (not Federal funds received by the state to establish the Exchange).

With establishment of an Exchange, the existing relationship between brokers, carriers, and consumers is likely to change. The ACA leaves states flexibility to make decisions regarding these relationships, such as designating an official role for brokers within the Exchange apparatus, requiring certification, or regulating commissions.

D. Increase Access to and Portability of High Quality Health Insurance

The ACA requires that health plans that wish to participate in an Exchange (Qualified Health Plans) comply with certain requirements related to marketing, choice of providers, plan networks, and essential health benefits. Beyond this, states may establish additional requirements for plans that are offered on an Exchange.

The ACA provides states with the option of operating a Basic Health Program for individuals between 133% and 200% of the federal poverty level, in lieu of those individuals receiving premium subsidies for purchase of coverage. The benefits under the Basic Health Program must be at least equivalent to the essential health benefits and premiums may not be higher than those in the Exchanges.

With health care reform, individuals may be eligible for one of a variety of insurance options: Medicaid, CHIP, subsidized coverage through an insurance Exchange, and unsubsidized coverage through an Exchange. The ACA requires that there should be a single seamless process of applying for coverage for all of these programs – regardless of where a consumer enters the system.

E. Ensure Greater Accountability and Transparency

The ACA requires that Exchanges post information on the cost and quality of health plans. Specifically, states must develop an Internet website for standardized comparative information on plans, provide public ratings of participating Exchange plans, and use a standard format for presenting health plan options in the Exchange.

F. Self-Sustaining Financing

The ACA includes grant funding for planning and establishment of Exchanges, but beginning January 1, 2015, state Exchanges must be financially self-sustaining.

The ACA establishes a minimum essential benefit set to be sold inside and outside an Exchange. A state may choose to require additional benefits but must cover the cost of those benefits for individuals eligible for tax credits through an Exchange.

G. Under the ACA, an Exchange is responsible for performing a specified list of functions. However, many decisions are left to the states.

Under federal law, the Exchange is required to perform these functions:

- Certify, recertify, and decertify qualified health benefits plans under the guidelines established by the federal Department of Health and Human Services (HHS)
- Operate a toll-free customer assistance hotline
- Maintain a website that allows customers to compare qualified health benefits plans offered by different insurance carriers
- Assign a rating to each qualified health plan under the rating system that will be established by HHS
- Use a standardized format to present four coverage options (bronze, silver, gold, and platinum), plus the catastrophic plan design for young adults/exemptions
- Inform individuals about the existence of—and their eligibility for—public programs, including but not limited to Medicaid and Children's Health Insurance Program (CHIP)
- Certify individuals who are exempt from the individual mandate on the basis of hardship or other criteria to be established by HHS
- Transfer information to the federal Secretary of Treasury regarding individual mandate exemptions and subsidies awarded due to a failure on the part of a small employer to provide sufficient affordable coverage
- Provide information to employers on their employees who are not covered
- Establish a network of navigators to raise awareness among customers of their coverage options and to help people select and enroll in health plans and subsequently access benefits